TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STONEGATE SURGERY CENTER, LP

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-17-2485-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
April 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2016 Texas Ambulatory Surgical Center Fee Schedule."

Amount in Dispute: $872.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the reimbursement for the procedure codes at issue and contends the Provider has been appropriately reimbursed under the applicable Maximum Allowable Reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2016	Ambulatory Surgery, Procedure Code 27096	$872.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - 300 – AN ALLOWANCE HAS BEEN MADE FOR A BILATERAL PROCEDURE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards reimbursement for the facility services of an ambulatory surgical center subject to 28 Texas Administrative Code §134.402(f), which requires the calculation used to establish the maximum allowable reimbursement (MAR) shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement is based on the payment amount as listed in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES applicable to the date of service.

   Rule §134.402(d) requires that, for coding, billing, and reporting, of ASC facility services, system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rules.

   The disputed procedure code, CPT 27096, was not found on Medicare's ASC Covered Surgical Procedures Addendum AA for Calendar Year 2016.

   Per Medicare payment policy, Under the ASC payment system, Medicare makes facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures.

   Rule §134.402(i) provides that If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

   (1) The agreement may occur before, or during, preauthorization.
   (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.
   (3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:
      (A) the reimbursement amount;
      (B) any other provisions of the agreement; and
      (C) names, titles and signatures of both parties with dates.

   The requestor did not present documentation of any such agreement.

   The requestor provided a "payment breakdown from their 2016 Workers Compensation Case Calculator that shows the correct National Rate and Wage Index to be used to calculate the correct Fee Schedule Allowed Amount."

   The requestor's calculated rate is based on HCPCS code G0260. However, the health care provider did not bill HCPCS code G0260 to the insurance carrier—but rather CPT code 27096 (with modifiers LT and RT). Review of this information finds it unpersuasive.

   The respondent presented documentation of payment by the insurance carrier with additional payment advisement noting that "REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE."

   Based on review of the information submitted by the parties, the division concludes the requestor has failed to support that any additional payment is due. Consequently, additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.